



Therapeutic Shoes and Inserts

Physician Prescription

(Complete patient information OR attach patient face sheet when faxing.)

Patient Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____ Date of Birth _____

Primary Payor _____

Secondary Insurance _____

Diagnosis _____ ICD-9 Code _____

Order: 1 Pair Diabetic Shoes Inserts: 3 pair 2 pairs 1 pairs
 Custom Shoes Custom Molded Inserts

Physician Name (Printed): _____

Physician NPI #: _____

Physician Phone: _____ Fax: _____

Physician Signature _____ Date _____

Patient seen within last 3 months to address diabetes management.

Patients: Please call ahead for an appointment.

STATEMENT OF CERTIFYING PHYSICIAN

Therapeutic Shoes

(This portion must be completed by MD or DO)

I certify that **ALL** of the following statements are true:

- This patient has diagnosis of Diabetes Mellitus.
- This patient also has one or more of the following conditions
(Must check at least one.)
 - History of partial or complete amputation of foot
 - History of previous foot ulceration
 - History of pre-ulcerative callus
 - Peripheral neuropathy with evidence of callus formation
 - Foot deformity
 - Poor circulation
- I am treating this patient under a comprehensive plan of care for his/her condition.

Patient's Name: _____

HIC Number: _____

Physician Name (Printed): _____

Physician Signature _____ Date _____

Physician NPI #: _____

Physician Address: _____

- This patient needs special shoes (depth or custom molded shoes) because of his/her diabetes.

Erie, PA:	1700 Peach Street	Phone: (814) 877-6121	Fax: (814) 455-9440
Bradford, PA:	600 Chestnut Street	Phone: (814) 362-8141	Fax: (814) 362-9113
Meadville, PA:	303 Chestnut Street	Phone: (814) 337-6900	Fax: (814) 337-6902
Jamestown, NY:	512 W. Third Street	Phone: (716) 664-5092	Fax: (716) 664-6570
Fredonia, NY:	37 W. Main Street	Phone: (716) 672-4704	Fax: (716) 672-4706